STATE OF ALABAMA

DEPARTMENT OF INSURANCE

MONTGOMERY, ALABAMA

REPORT OF EXAMINATION

of

BLUE CROSS AND BLUE SHIELD OF ALABAMA

BIRMINGHAM, ALABAMA

as of

DECEMBER 31, 2002

TABLE OF CONTENTS

EXAMINER'S AFFIDAVIT

STATE OF ALABAMA
COUNTY OF Jefferson

Palmer W. Nelson, being first duly sworn, upon his oath

deposes and says:

That he is an examiner appointed by the Commissioner of Insurance for the State of Alabama;

That an examination was made of the affairs and financial condition of Blue Cross and Blue Shield of Alabama for the period of January 1, 1999 through December 31, 2002;

That the following 46 pages constitute the report thereon to the Commissioner of Insurance of the State of Alabama Department of Insurance;

And that the statements, exhibits and data therein contained are true and correct to the best of his knowledge and belief.

Palmer W Nelson
Examiner-in-charge

Subscribed and sworn to before the undersigned authority this 28 day of JUNE, 2004.

Janice L Thomas
(Signature of Notary Public)

Janice L. Thomas, Notary Public
(Print Name)

in and for the State of Alabama.

My Commission expires 9-16-04

BOB RILEY
GOVERNOR

STATE OF ALABAMA
DEPARTMENT OF INSURANCE
201 MONROE STREET, SUITE 1700
POST OFFICE BOX 303351
MONTGOMERY, ALABAMA 36130-3351
TELEPHONE: (334) 269-3550
FACSIMILE: (334) 241-4192
INTERNET: www.aldoi.org

WALTER A BELL
COMMISSIONER

DEPUTY COMMISSIONER
JAMES R. (JOHNNY) JOHNSON
D DAVID PARSONS

CHIEF EXAMINER
RICHARD L. FORD

STATE FIRE MARSHAL
JOHN S. ROBISON

GENERAL COUNSEL
MICHAEL A. BOWNES

RECEIVER
DENISE B. AZAR

PRODUCER LICENSING MANAGER
JIMMY W. GUNN

Birmingham, Alabama
June 22, 2004

Honorable Walter A. Bell
Commissioner of Insurance
State of Alabama
Department of Insurance
201 Monroe Street, Suite 1700
P.O. Box 303351
Montgomery, Alabama 36130-3351

Dear Commissioner Bell:

Pursuant to your authorization and in compliance with ALA. CODE § 10-4-110 (1975), an examination has been made of the affairs and financial condition of:

BLUE CROSS AND BLUE SHIELD OF ALABAMA
BIRMINGHAM, ALABAMA

at its home office located at 450 Riverchase Parkway East, Birmingham, Alabama 35244, as of December 31, 2002. The report of examination is submitted herewith.

Where the description "Company" or "BCBSAL" appears herein without qualification, it will be understood to indicate Blue Cross and Blue Shield of Alabama. Where the description "UTIC" appears herein without qualification, it will be understood to indicate United Trust Insurance Company.

SCOPE OF EXAMINATION

The Company was last examined for the five year period ended December 31, 1998. The current examination covers the intervening four year period from the date of the last examination through December 31, 2002. The examination was conducted concurrently with the examination of the Company's insurance subsidiary, United Trust Insurance Company (UTIC), located in Birmingham, Alabama. Transactions subsequent to 2002 were reviewed where deemed appropriate.

The examination was made in accordance with the statutory requirements of the State of Alabama for a Health Care Service Plan as provided for in ALA. CODE § 10-4-100 (1975) through § 10-4-115 (1975); and in accordance with Alabama Insurance Department regulations; in addition to the procedures and guidelines promulgated by the National Association of Insurance Commissioners (NAIC), as deemed appropriate; and in accordance with generally accepted examination standards and practices.

The examination included an inspection of Company records, test checks of recorded income and disbursement items for selected periods, and a general review of records and files pertaining to operations, administrative practices and compliance with statutes and guidelines. Assets were verified and valued and all known liabilities were established or estimated as of December 31, 2002, as shown in the financial statements contained herein. The discussion of assets and liabilities contained in this report is confined to those items where a material change was made; which indicated violation of the applicable statutes and/or regulations; or where comments and/or recommendations were deemed appropriate.

The Company's office copy of the filed 2002 Annual Statement was compared with or reconciled to general ledger account balances.

The Company, doing business as Cahaba Government Benefit Administrators, acted as a fiscal intermediary and carrier under Parts A and B of the U.S. Center for Medicare and Medicaid Services' (formerly Health Care Financing Administration) Medicare program. Under this program, the Company disbursed federal funds to physicians, hospitals and others on the basis of incurred claims for medical services provided. Neither the remittances received nor the corresponding charges for claims paid were reflected in the Company's financial statements. Amounts due the Company for administering the program were based on cost computations and were recorded as receivables. The records of claims and allowable administrative cost reimbursements were audited by governmental auditors or outside certified public accounting (CPA) firms. Final settlements for contractual periods are based on the audits. Examination of the Medicare program was limited to cash accounts and receivables for reimbursement of administrative costs.

The Company maintains an Internal Audit Department. Reports generated by the Internal Audit Department were made available to the examiners and were used in the examination as deemed appropriate.

BCBSAL is audited annually by a CPA firm. The CPA's work papers were reviewed and were used in the examination as deemed appropriate by the examiners.

A market conduct examination was performed concurrent with the financial examination. The market conduct examination included a review of the Company's territory, plan of operation, district offices, advertising, claims processing, policy forms and underwriting, producer licensing, treatment of policyholders and claimants, and privacy standards. See page 20 for further discussion of the market conduct examination.

A signed certificate of representation was obtained during the examination. In this certificate, management attested to having valid title to all assets and to the nonexistence of unrecorded liabilities as of December 31, 2002.

ORGANIZATION AND HISTORY

The Company was organized January 15, 1935, as the Hospital Service Corporation of Alabama, under the laws of the State of Alabama providing for the organization and regulation of nonprofit corporations for the establishment of health service plans. The certificate of incorporation was filed for record in the office of the Judge of Probate of Jefferson County, Alabama. An amendment to the certificate of incorporation, adopted at the regular annual meeting of the Board of Trustees held on February 20, 1952, changed the Company's name to Blue Cross-Blue Shield of Alabama.

To comply with changes required by Act Number 1041, enacted by regular session of the Alabama Legislature of 1973, the Board of Directors held a meeting October 24, 1973, and adopted several amendments to the certificate of incorporation and a revised set of Bylaws. The name of the corporation was changed to Blue Cross and Blue Shield of Alabama and the Board's composition was changed to reflect a majority of public directors.

To comply with the 1973 legislative changes, the object and purpose of the Company was amended in the certificate of incorporation, as follows:

> To establish, maintain, and operate health care service plans under which health services of all types and forms and other services and commodities incidental thereto may be furnished to such of the public who, under the rules and regulations of the Corporation, make application and are eligible therefore; and to carry on any other lawful business whatsoever which may seem to the Corporation capable of being carried on in connection with the above, or calculated directly or indirectly to promote the interests of the Corporation or to enhance the value of its properties or the conduct of its business and affairs.

The Bylaws were amended by approval of the Board of Directors in a meeting held on August 22, 1990. This amendment changed the duties of the office of Treasurer to reflect the actual responsibilities of that position, deleted the reference to a Vice Chairman of the Board, and changed the position of Executive Vice President from a required position to an optional position.

No amendments to the Company's Certificate of Incorporation or Bylaws were made during the current examination period.

Blue Cross and Blue Shield of Alabama is a non-stock not-for-profit corporation organized under ALA. CODE § 10-4-100 (1975) which provides that:

> Any non-stock corporations organized not for profit for the purpose of establishing, maintaining and operating a health care service plan under which health services are furnished to such of the public who become subscribers to such plan pursuant to contracts are authorized and shall be governed by the provisions of this article.

At December 31, 2002, the Company had three wholly owned subsidiaries. The three wholly owned subsidiary entities wholly owned an additional two subsidiaries. All five of the entities were domiciled in Alabama. These subsidiaries are shown under the caption, "Holding Company and Affiliate Matters – Organizational Chart", found on page 17.

The Company is a health care service plan as defined by ALA. CODE § 10-4-100 (1975). The NAIC annual statement blank currently utilized by the Company is the Health Blank. Prior to January 1, 2001 the Company utilized the Hospital, Medical and Dental Service or Indemnity Corporations (HMDI) Blank.

Effective January 1, 2001, changes were made in the manner in which BCBSAL prepared its statutory financial statements for the Company's financial reporting to be in accordance with the SSAP No. 47, Uninsured Plans. The cumulative effect of these changes in accounting principles was reported as an adjustment to unassigned funds in the period of the change in accounting principle. The changes in financial reporting involved excluding all income and expenses related to claims, losses, premiums and other amounts received or paid on behalf of the administrator in relation to uninsured plans from the statement of operations.

MANAGEMENT AND CONTROL

Board of Directors

The enabling statutes, generally, and the Bylaws, specifically, provide that the management and control of the business, property and affairs of the Company shall be vested in the Board of Directors, which shall have all of the powers of the Company. Article I, Section 2 of the Bylaws provided that:

> The Board of Directors shall be composed of twenty-seven persons, consisting of the following:
>
> a) fourteen public directors, who shall reflect the social, economic, and geographic characteristics of the population served by the Corporation
> b) the Chief Executive Officer of the Corporation, who shall be a member of the Board during and by virtue of occupancy of the chief executive office of the Corporation, or, when the office of the Chief Executive Officer is vacant, the President of the Corporation who shall be a member of the

Board during and by virtue of occupancy of the office of President while the office of Chief Executive Officer remains vacant;

c) six directors who shall be representatives of health care facilities participating as members of the Corporation in accordance with Section 10-4-102 of the Alabama Code of 1975; and

d) six directors who shall be members of the medical profession in the State of Alabama.

No Director (except the Chairman of the Board, the Chief Executive Officer and the President) who has served for two consecutive three-year terms is eligible for re-election until he or she has not served on the Board for one year.

The composition of the Board of Directors, described above, complies with ALA. CODE. § 10-4-103 (1975), which states in part;

> The board shall be composed of not less than 15 nor more than 27 directors....Providers of health care and their representatives may also serve on the board, but in no event may constitute a majority thereof. Persons who derive income from the delivery or administration of health care or services shall not be eligible to serve as public directors.

Board members elected and serving at December 31, 2002 were as follows:

Directors/Residence	**Principal Occupation**
James Malcom Aycock Decatur, Alabama	President Cooks Pest Control
Glen Owen Bailey Fairhope, Alabama	President and Chief Executive Officer Thomas Hospital
Donald Maurice Ball Montgomery, Alabama	President and Chief Executive Officer Jackson Hospital and Clinic
Thomas Benton Bender, Jr. Mobile, Alabama	President Bender Shipbuilding and Repair
Edward Franklin Crowell Hope Hull, Alabama	Vice President Administration Miltope Corporation
Russell McWhorter Cunningham, III Birmingham, Alabama	President Birmingham Realty Company
Dan Meadow Eager, Jr. Bessemer, Alabama	Administrator UAB Medical West
Leonidas Keith Granger Dothan, Alabama	President and Chief Executive Officer Flowers Hospital
Robert Anthony Guthans Mobile, Alabama	Retired - Former President and Chief Executive Officer Midstream Fuel Service, Inc.

Kenneth Earl Hubbard Birmingham, Alabama	President Western Supermarkets
Horace Linwood Jones Birmingham, Alabama	Chief Executive Officer BCBSAL
Bryan Neal Kindred Tuscaloosa, Alabama	President and Chief Executive Officer DCH Health Systems
Donald Lee Large, Jr. Ed.D. Auburn, Alabama	Executive Vice President Auburn University
Helen Shores Lee Birmingham, Alabama	Circuit Judge Jefferson County Circuit Court
William Augustus Howe MacLean, M.D. Birmingham, Alabama	Physician Alabama Cardiovascular Group
Billy Albert Mason Mobile, Alabama	President and Chief Executive Officer Springhill Memorial Hospital
Frank Emmett Meyer, Jr. Tuscaloosa, Alabama	President, Human Resources and Administration Mercedes-Benz U.S. International, Inc.
Manly Eugene Moor, Jr. Birmingham, Alabama	Retired in 1994 from AmSouth Bank Former Vice Chairman of the Board
Paul Clifford Morrow Elba, Alabama	Retired PCM Services, Inc.
Joel Candler Pittard, M.D. Opelika, Alabama	Physician Lee Obstetrics and Gynecology
Stancel Martin Riley, Jr. M.D. Huntsville, Alabama	Physician Huntsville Cardio Thoracic Surgeons
James Michael Segrest Huntsville, Alabama	President and Chief Executive Officer The Spencer Companies
James Edger Shotts, Jr., M.D. Tuscaloosa, Alabama	Physician Tuscaloosa Ear, Nose and Throat
William Jackson Stevens Birmingham, Alabama	President and Chief Executive Officer Motion Industries, Inc.
Burt Fowler Taylor, M.D. Mobile, Alabama	Physician Orthopedic Group
Richard Wayne Waguespack, Sr., M.D. Birmingham, Alabama	Physician Private Practice, Otolaryngology
Charlie Joe Wilson Florence, Alabama	Retired - Former Regional Industries Relations Director Reynolds Metal Company

Committees

Executive committee

Article I, Section 14 of the Bylaws provided that the Company shall have an Executive Committee of the Board of Directors with authority to act as follows:

> During intervals between meetings of the Board of Directors the Executive Committee shall have, subject to the control and direction of the Board, the authority to exercise any and all of the powers and to perform any and all duties of the Board of Directors as may lawfully be exercised and performed by such Committee.

The following directors were elected to the Executive Committee at the Board meeting of March 27, 2002 and were serving at December 31, 2002:

Manly Eugene Moor, Jr., Chairman
Robert Anthony Guthans
Horace Linwood Jones
Billy Albert Mason
William Jackson Stevens
James Edger Shotts, Jr., M.D.
Charlie Joe Wilson

Hospital Advisory Committee

Article I, Section 13 of the Bylaws provided that the Board of Directors shall establish a Hospital Advisory Committee consisting of five hospital representatives who are not members of the Board and are knowledgeable in providing health services. "The Advisory Committee shall from time to time, as requested by the Board of Directors or any committee thereof, consult and advise with the Board of Directors or any committee or member thereof concerning matters as to which consultation or advice is requested by such Board or committee."

The following persons were elected to the Hospital Advisory Committee at the Board meeting held March 27, 2002 and serving at December 31, 2002:

Larry Joseph Austin
Harold Reed
Jennie Rogers Rhinehart
Stanley Keith Hammack
William Herman Anderson

Other Committees

Article I, Section 15 of the Company's Bylaws provided that, "The Board of Directors or the Chairman of the Board may appoint such committees from the members of the Board as

may be deemed necessary or advisable and may prescribe their respective powers, authorities and duties."

These other committees were in addition to the Executive Committee and the Hospital Advisory Committee, both of which were required by the Company's Bylaws.

The following Committees had been established and existed at December 31, 2002:

Audit Committee
James Malcom Aycock, Chairman
Donald Lee Large, Jr.
Donald Maurice Ball
Manly Eugene Moor, Jr.
James Edger Shotts, Jr.

Medical Review Committee
Richard Wayne Waguespack, M.D., Chairman
James Edger Shotts, Jr., M.D.
Joel Candler Pittard, M.D.
Stancel Martin Riley, Jr., M.D.
William Augustus Howe MacLean, M.D.
Burt Franklin Taylor, M.D.

Salary Review Committee
William Jackson Stevens, Chairman
James Michael Segrest
Billy Albert Mason
Manly Eugene Moor, Jr.
Stancel Martin Riley, Jr., M.D.

Nominating Committee
Dan Meadow Eagar, Jr., Chairman
Leonidas Keith Granger
Richard Wayne Waguespack, Sr., M.D.
Helen Shores Lee
Manly Eugene Moor, Jr.

Physicians Advisory Committee
James Edger Shotts, Jr. M.D., Chairman
Robert Phillip Robichaux, M.D.
Clarence Neal Canup, M.D.
John Allen Higginbotham, M.D.
Lucian Newman, III, M.D.
Nancy Elizabeth Dunlap, M.D.
Howard Joseph Falgout, M.D.

Facility Standards and Membership Committee
**John Barton Crowe, Sr., Chairman
Manly Eugene Moor, Jr.
**Terry Wayne Andrus
**Clarence Neal Canup, M.D.
**William Eugene Davenport
**Malcolm Dunkin Smith

Retirement Review Committee
Charlie Joe Wilson, Chairman
Frank Emmett Meyer, Jr.
Paul Clifford Morrow
Manly Eugene Moor, Jr.
**Pamela Duncan Varner, M.D.

**At December 31, 2002 these Directors were no longer serving and were not yet replaced.

The following Committee was dissolved in November of 2002:

Payment Safeguard Contractor Steering Committee
Manly Eugene Moor, Jr.
Russell McWhorter Cunningham, III
*Malcolm Dunkin Smith

*Retired from the Board before the dissolution of the Committee and no replacement was appointed.

Officers

The following officers were elected by the Board of Directors at the March 27, 2002 meeting and were serving at December 31, 2002:

Chairman of the Board	Manly Eugene Moor, Jr.
Chief Executive Officer	Horace Linwood Jones
President and Chief Operating Officer	Gary Phillip Pope
Vice President	Joseph Benjamin Bolen, III
Vice President	James Martin Brown
Vice President	Jerry Wayne Chambers
Vice President	Paul Edward Dixon, Jr.
Vice President	Edward Owen Harris
Vice President	Charles Ray Hartsell
Vice President	Walter Thomas Hudgins, Jr.
Vice President	James Coleman Justice
Vice President and Treasurer	Terry Dee Kellogg
Vice President	Richard Colin King
Vice President	Timothy Lee Kirkpatrick
Vice President	John Paul Kovac
Vice President	Janet Dean McGowin

Vice President	William Allen Moon
Vice President	William Richard Nash
Vice President	Lynda Glass Northcutt
Vice President	Patrick Earl Ryce, M.D.
Vice President	Leigh Logan Stevens
Vice President	Janet Perry Stewart
Vice President and Secretary	Arthur Grey Till, Jr.
Vice President	Timothy Vines
Assistant Secretary	Francis Palmer Cooley
Assistant Secretary	Amanda Cockrell Bradley

Code of Business Conduct and Compliance Program (Conflict of Interest)

The Company requires that conflict of interest statements be completed annually by all directors, officers and exempt status employees. In addition, the Company requires every new employee; whether they are exempt, non-exempt, full-time, part-time or contracted; to attend a Code of Business Conduct and Compliance Program.

The Code of Business and Compliance Program provides employees with a formal statement of the Company's standards and rules of ethical business. According to management, this program is usually conducted on the second day of employment. At the end of the program the employee is required to sign a statement of understanding, which is maintained in the employees personnel file.

A review was conducted of all conflict of interest statements filed by the Board of Directors and the Officers for the years covered by the examination. No items of disclosure which seemed to have the potential of a material or adverse impact on the operations of the Company were noted.

CORPORATE RECORDS

The Certificate of Incorporation and Bylaws, as amended, were inspected during the course of the examination and appeared to provide for the operation of the Company in accordance with usual corporate practices and applicable statutes and regulations.

Minutes of the meetings of the Board of Directors and various committees were reviewed for completeness. Actions taken on matters brought before the Board for deliberation and actions taken during the examination period were reviewed. The minutes of Board meetings held during the examination period did not include the proper authorizations for investments. The minutes for the Board of Directors meetings during the examination period included the approval of the financial report for the preceding month. The financial report that was approved by the Board of Directors contained a consolidated statement of operations, balance sheet, statement of changes in unassigned funds, notes to the financial statements, and supplemental financial data, but did not contain information on the Company's investment transactions.

It was again noted that the minutes for the Board of Director's meetings during the examination period did not reflect approval, or ratification, for the purchase or sale of investments. It was also noted that in the 2002 Annual Statement, general interrogatory number 11, "Is the purchase or sale of all investments of the corporation passed upon either by the Board of Directors or a subcommittee thereof?" was answered yes. The same answer was given to the like interrogatories in the 1994 - 2001 Annual Statements.

The related recommendations are located on Page 41, under the caption "Compliance with Previous Recommendations – Corporate Records."

HOLDING COMPANY AND AFFILIATE MATTERS

Holding Company

United Trust Insurance Company (UTIC) is a wholly owned subsidiary of Alabama Industries Financial Corporation (AIFC). AIFC is a wholly owned subsidiary of the Company. See page 17 for an organizational chart, which presents affiliated corporate relationships. UTIC is subject to the Alabama Insurance Holding Company System Regulatory Act as defined in ALA. CODE § 27-29-1 (1975). In connection therewith, UTIC is registered with the Alabama Department of Insurance as registrant of an Insurance Holding Company System. Appropriate filings required under the Holding Company Act were made from time to time on behalf of the Company by UTIC as registrant, except as under the heading "Management and Service Agreements" on page 13.

Franchise Affiliation

The Company is affiliated with and is a franchisee of the Blue Cross and Blue Shield Association (Association), which is located in Chicago, Illinois. The Company pays annual dues to the Association in order to continue the right to use the Blue Cross and Blue Shield names and servicemarks (i.e., trademarks), and to benefit from the services provided by the Association. Association dues charged to each Plan are based on a formula, which uses a graduated scale computed on a combination of total subscription (premium) revenue and subscription revenue per contract.

There are forty-one "Blue Cross" and/or "Blue Shield" plans affiliated by virtue of Association franchisees in the United States and Puerto Rico. Approximately twenty plans are statewide or U.S. possession organizations with the remaining plans covering only a specific county, territory, or area. The Company's franchise is a statewide plan.

A few of the plans did not cover both Blue Cross and Blue Shield coverage within the same plan. Generally, the term "Blue Cross" refers to coverage provided for hospital inpatient and outpatient; "Blue Shield" refers to coverage provided for physicians, including major medical, dental and eye care. The Company's franchise covered the State of Alabama and includes both "Blue Cross" and "Blue Shield" coverage.

The Association provided various services to BCBSAL, among which are the following:

A) Congressional Legislative Liaison
B) National marketing
C) Research and development of new products
D) Competition studies
E) Studies of national trends
F) Training workshops for new staff in standardized areas, such as:
   Hospital Auditing
   Underwriting
   Accounting
   Other functions common to all plans
G) Operation and availability of Blue Card and Inter-Plan Teleprocessing System – a system network used for inter-plan accounting for provider services provided by one Plan to another "Plan's" cardholder (or subscriber), when the card holder is outside their "Plan's" territory
H) National Contractor for Medicare Part A and Federal Employee Programs, through which BCBSAL participates

The BCBSAL is required under the license (franchise) agreement to meet governance, financial, and operational requirements and standards imposed by the Association. The Company is also required to produce and provide various reports to the Association.

Generally, services provided to a Plan's cardholder ("subscriber"), while in another Plan's territory, are handled through the Inter-Plan Teleprocessing System, as discussed above (item "G"). There are complexities when dealing with certain national accounts, such as when a Plan acted in a "Control Plan – Par Plan" arrangement.

The "Control Plan – Par Plan" operates in a manner whereby the Control Plan holds the master contract with a company (employer.) The Control Plan is responsible for all administrative functions for their customers (employers) including maintaining benefits, eligibility, ID card production, customer service and all claims processing. The Participating Plans assist the Control Plan by hosting the Control Plan's membership in the Par Plan service area. The Par Plan is responsible for collecting, keying, pricing and electronically transmitting claims incurred in their service area to the Control Plan for processing. After claims have been processed by the Control Plan, the Par Plan transmits payment to their providers. All accounting for claim processing, claim expense and risk associated therewith flows through the Control Plan's financial statements. An administrative expense allowance is paid to the Participating Plan.

The BlueCard Program allows members without BlueCard PPO (defined in the following paragraph) to access other Plans' traditional providers. The discounts, hold harmless clauses, and claims filing clauses that other Plans have negotiated with their providers apply when services are provided to subscribers while outside of the local Plan's service area. Groups automatically fall under this program if they do not have BlueCard PPO.

BlueCard PPO is a nationwide PPO program sponsored by the Blue Cross and Blue Shield Association and is symbolized by the "PPO in a suitcase" logo on the I.D. card. Nearly all of the Blue Cross and Blue Shield Plans having a PPO network participate in this program.

This program is frequently used to consistently administer PPO benefits for groups that do not qualify as National Accounts, but have employees outside of the local Plan's service area. In 1995, the Association's Brand Development and Promotion Committee approved, and the Association's Board of Directors authorized, a program to recognize and reward those Plans which surpass other Plans in enhancing the collective image of the Blue Cross and/or Blue Shield Brands. This program is called the "Brand Excellence Awards Program". The Company has won this award for the years 1995 through 2003.

Management and Service Agreements

The Company was unable to provide approval letters from the Commissioner of Insurance for the management and service agreements between the Company and Alabama Industries Financial Corporation, Cahaba Safeguard Administrators, and The Caring Foundation. It was recommended in the previous examination report that the Company obtain approval from the Commissioner of Insurance for its management and service agreements as required by ALA. CODE § 27-29-4 (1975). The related recommendation can be found on page 41 under the heading "Compliance with Previous Recommendations – Management and Service Agreements."

BCBSAL provided various services to the following affiliated companies at December 31, 2002:

A) United Trust Insurance Company
B) Alabama Child Caring Foundation
C) Alabama Industries Financial Corporation
D) The Caring Foundation
E) Preferred Care Services, Inc.
F) Cahaba Safeguard Administrators, LLC

Additional information regarding the affiliated companies in the Holding Company System is included in this report on page 11 under the heading "Franchise Affiliation" and on page 20 under the heading "Plan of Operation."

The summaries which follow present the pertinent information related to the affiliated companies and any management and service agreements in effect with the companies at December 31, 2002.

A) United Trust Insurance Company (UTIC)

BCBSAL entered into an administrative services agreement with an effective date of January 1, 1990 with UTIC. The agreement provides that the Company will furnish administrative services to UTIC including facilities, personnel, accounting, legal, and auditing services. The agreement states that a set monthly fee is to be paid to the Company for the services provided. The amount may be adjusted by giving UTIC thirty days advance notice. The charge is to be based on BCBSAL's cost to provide such services on a non-profit basis. The agreement was amended December 7, 1999 to document the increase in the monthly administrative fee that had been in place since August 1, 1992.

B) Alabama Child Caring Foundation (ACCF)

BCBSAL entered into an administrative service agreement with ACCF on June 7, 1989, effective March 1, 1988. The agreement states that BCBSAL will provide at no cost the following services:

a) Administer the benefits provided by ACCF, subject to all of the terms and conditions of the benefit plan and to the terms and conditions of the agreement;
b) Furnish application forms and material necessary and appropriate for the enrollment of subscribers and provide ACCF such assistance as reasonably necessary to the enrollment process;
c) Issue identification cards to each subscriber enrolled and certified as eligible by ACCF to evidence the subscriber's entitlement to benefits under the plan;
d) Provide ACCF with claim cost projections, analyses, and other actuarial and statistical data as may be reasonably requested by ACCF in its management of the plan. The agreement was amended on March 9, 1995 to add:
e) Claims administrator shall also provide all managerial and other overhead functions and services, including all necessary and appropriate accounting, equipment, utilities, supplies, legal compensation and benefits, payroll and similar services at no cost to ACCF.

In addition to the above agreement, BCBSAL also matches dollar for dollar all contributions that are made to ACCF.

Alabama Industries Financial Corporation (AIFC)

BCBSAL entered into an administrative services agreement with AIFC on May 20, 1992. The agreement provides that the Company will provide the following services:

a) Prepare all necessary legal documents, including regulatory, tax and other governmental filings for the conduct of AIFC's business;
b) Perform all functions associated with the marketing of AIFC's business;
c) Act on behalf of AIFC for the purpose of negotiating, coordinating and servicing activities necessary to implement this agreement or to conduct AIFC's business;
d) Provide all data processing, accounting and legal services necessary for AIFC operations;
e) Supply personnel staffing and office equipment as needed;
f) Provide such other managerial, administrative and professional services as may reasonably be necessary for the conduct of AIFC's business.

C) The Caring Foundation (TCF)

BCBSAL entered into an administrative services agreement with TCF on December 1, 1991, effective January 1, 1991. The agreement provides that BCBSAL is to provide TCF with accounting, data processing, legal services, and other managerial, administrative and professional services as may be reasonably necessary for the conduct of TCF's business. TCF agrees to reimburse BCBSAL for its cost of providing such services on a non-profit basis. TCF is a charitable corporate foundation formed to "insure that the Company will

have adequate funds into the future available for handling civic obligations." TCF was originally funded in 1991 with a $13 million contribution from the Company. The term of this agreement is one year. The agreement automatically renews unless written notification is made by either party 180 days before the end of the term.

D) Preferred Care Services, Inc. (PCS)

The Company entered into an administrative services agreement with PCS on May 23, 1989, effective June 1, 1989. The agreement provides that PCS wishes to contract with the Company to provide administrative and managerial services, personnel, facilities, and experience and expertise in marketing their services. The agreement is for successive like terms of one year unless either party gives the other written notice 180 days before the end of the one year term.

The agreement was amended on June 3, 1998 with an effective date of January 1, 1998 to include the following:

1) The Company is to reimburse PCS for administrative services provided by the agreement.
2) PCS shall enter into contractual agreements with pharmacies and other health care entities in order to provide clinical pharmacy management for the Company's participants. A mutually agreed upon fee will be paid to PCS by the Company.

F) Cahaba Safeguard Administrators, LLC (CSA)

The Company entered into an administrative services agreement with Cahaba Safeguard Administrators, LLC as of June 1, 2002. The agreement provides that CSA wishes to contract with the Company to provide facilities and administrative and staff support services that will enable CSA to provide Medicare Integrity Program services. CSA agreed to reimburse BCBSAL for such services on a non-profit basis. The agreement was to be in effect from June 1, 2002 through December 31, 2002 and then automatically renew for successive like terms of one year unless written notice to the contrary is given by either party to the other not less than 180 days before the end of any one year term.

The administrative agreement was amended July 5, 2002 effective on that date to include the following additional responsibilities of BCBSAL to be reimbursed by CSA on a non-profit basis:

1) To prepare and forward billings to and collect from CSA the fees prescribed for the provision of CSA services;
2) To perform consulting functions requested by CSA associated with bidding on task orders from Centers for Medicare and Medicaid Services for Medicare Integrity Services;
3) To provide all necessary support services, including but not limited to: LAN administration, human resource services, internal audit services,

telecommunication services, graphics services and legal services necessary for the business operation of CSA;

4) To supply office equipment, personal computers, furniture and other real and personal property as needed via a personal property lease;
5) To provide such other administrative and professional services as may reasonably be necessary for the conduct of CSA business operations.

Income Tax Allocation Agreement

The Company had an administrative services agreement with AIFC and PCS for the purpose of allocating income taxes among entities desiring to file a consolidated federal income tax return. The agreement was amended December 31, 1994 with a retroactive effective date of December 31, 1987 to document the standing practice relating to the filing of the consolidated Federal tax return. The Company did not have a formal written agreement prior to the 1994 amendment. The consolidated tax filing included BCBSAL, AIFC, PCS and their subsidiaries. The agreement provides that:

> In the event that there is a net operating gain for any calendar year, each subsidiary agrees to pay the Company an amount equal to twenty percent of the net operating gain. In the event that there is a net operating loss for any calendar year for a subsidiary, the Company agrees to pay an amount equal to twenty percent of the net operating loss.

The agreement renews automatically for successive like terms of one year unless written notice to the contrary is given by either party to the other not less than 180 days before the end of any one year term.

It was noted that these tax sharing agreements between the Company and its subsidiaries have not been approved by the Board of Directors as required by SSAP No. 10, paragraph 23 b. It was also noted that the Company's tax sharing agreements do not specifically state a settlement period. SSAP No. 10, paragraph 13 states:

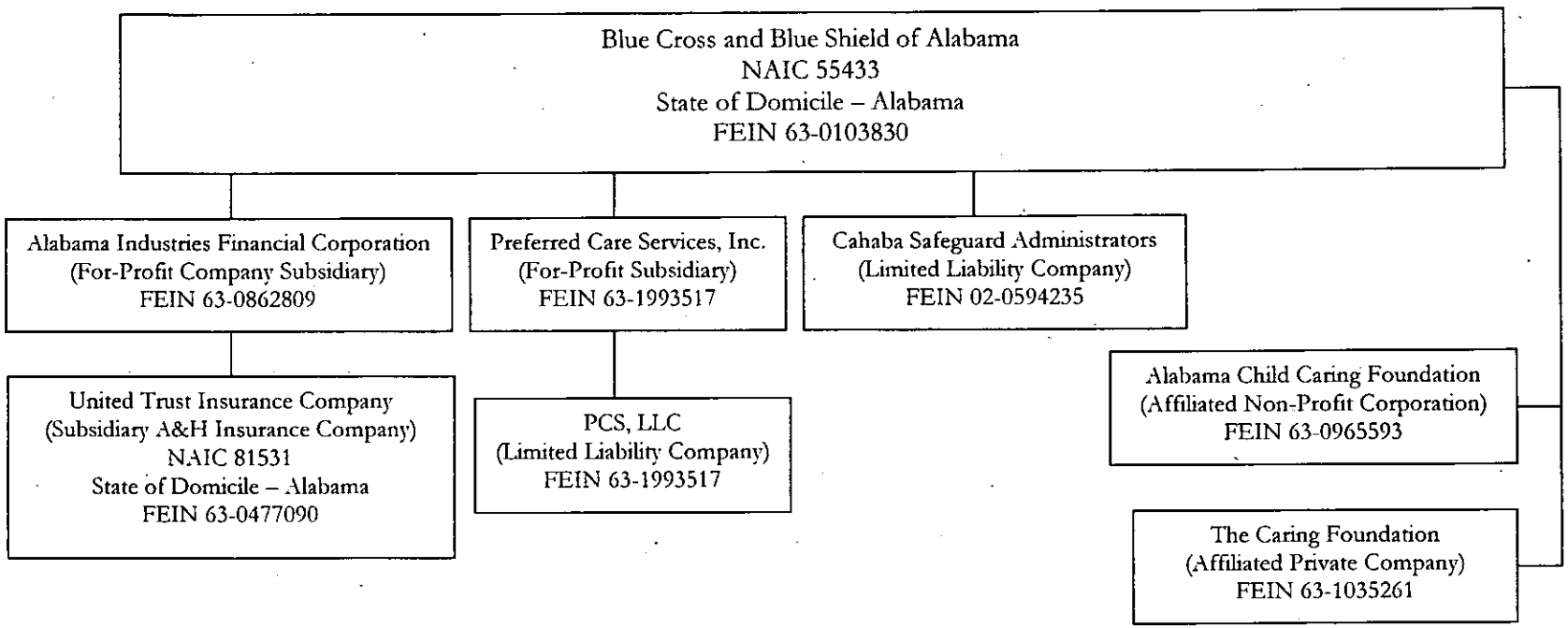
> Amounts owed to a reporting entity pursuant to a recognized transaction shall be treated as a loan or advance, and nonadmitted, pursuant to SSAP No. 25, to the extent that the recoverable is not settled within 90 days of the filing of a consolidated income tax return, or where a refund is due the reporting entity's parent, within 90 days of the receipt of such refund.

The Company provided a listing of intercompany settlement dates. These settlements were not completed within 90 days. However, the receivables that arose out of these agreements totaled $18,873, which was immaterial. Therefore, no changes were made to the financial statements. The related recommendations are located on page 42 under the heading "Important Points, Comments and Recommendations – Income Tax Allocation Agreement"

Organizational Chart

The following chart presents the corporate affiliations of the Company as of December 31, 2002.

Organizational Chart



DIVIDENDS TO STOCKHOLDERS OR POLICYHOLDERS

The Company is not a stock or a mutual corporation; therefore no dividends were paid by the Company. See page 3 for discussion of the Company's incorporation, under the caption "Organization and History."

FIDELITY BOND AND OTHER INSURANCE

The Company was a named insured with BCS Insurance Company for an aggregate amount which met the suggested minimum requirements of the NAIC Financial Condition Examiners Handbook. In addition to the above mentioned bond, BCBSAL also had insurance coverage for the following:

Property coverage with St. Paul Insurance Company;
Boiler and Machinery coverage with St. Paul Insurance Company;
Valuable paper coverage with St. Paul Insurance Company;
Computer hardware coverage with St. Paul Insurance Company;
Computer software coverage with St. Paul Insurance Company;
Flood/Quake coverage with St. Paul Insurance Company;
General liability coverage with St. Paul Insurance Company;
Employee benefits liability coverage with St. Paul Insurance Company;
Automobile coverage with St. Paul Insurance Company;
Umbrella (excess liability protection) coverage with St. Paul Insurance Company;
Non-Owned (leased) Aircraft coverage with W. Brown Associates Insurance Services;
Nurses liability coverage with Gulf Insurance Company;
Fiduciary Liability with Travelers Insurance Company; and
Directors and Officers coverage with BCS Insurance Company.

The coverage and limits carried by the Company were reviewed during the course of the examination and appeared to adequately protect the Company's interests as of the examination date.

EMPLOYEE AND AGENT WELFARE

The Company offered the following benefit plans for its employees and agents at December 31, 2002:

Vacation Leave
Sick Leave
Paid Holidays
Paid Jury Duty
Personal Leave
Funeral Leave
Military Pay Differential
Health Insurance
Group Travel Accident Insurance
Voluntary Travel Accident Plan
Tuition Reimbursement
Life, Accident, and Disability Insurance
401K Deferred Compensation
Retirement Plan
On-Premises Health Care
On-Site Sick Care for Children

Dental Insurance
Employee Assistance Program
Overtime Meal Allowance
Gain Sharing Program (for exempt)
Performance Based Pay (non-exempt)
Off Site Child Development Center
Dependent Care Assistance Plan
Birthday Gift Certificates
Service Incentive Award
Attendance Award (for non-exempt)
Credit Union Membership
Supplemental Benefit Plan
Air Med

A review of the benefit plans indicated that the plans appeared to be consistent with many industry plans and practices.

The Violent Crime Control and Law Enforcement Act of 1994, US Code, Title 18, Section 1033 (e)(1)(A), in part, prohibits individuals who have been convicted of specified criminal activity from engaging in the business of insurance without written consent from the [sic Alabama] Commissioner of Insurance. The Company, as part of its hiring procedures, required potential employees and contractors to disclose and explain any criminal convictions. The Company began performing criminal records checks on all job applicants in 1994 when the law became effective. The Company also required all employees to sign a conflict of interest statement yearly stating that they have not been convicted of a felony since becoming an employee of the Company. However, the Company had no way of knowing if an employee hired prior to 1994 had been convicted of a crime before becoming an employee. The related recommendation is located on page 42 under the heading "Important Points, Comments and Recommendations – Employee and Agent Welfare."

STATUTORY DEPOSIT

The following schedule reflects the statutory deposit held by the Alabama Department of Insurance as a condition of licensure at December 31, 2002:

Description	Par Value	Statement Value	Market Value
2.28% CD, due April 3, 2003	$30,000	$30,000	$30,000

FINANCIAL CONDITION AND GROWTH OF THE COMPANY

The following table sets forth the significant items indicating the growth and financial condition of the Company for the period under review. Effective January 1, 2001, the income and expenses related to claims, losses, premiums and other amounts received or paid on behalf of the administrator in relation to uninsured plans were excluded from the statement of operations resulting in significant changes from year end 2000 to year end 2001.

	2002*	2001	2000	1999	1998*
Admitted Assets	$1,267,480,836	$1,141,211,466	$1,441,275,430	$1,337,467,025	$1,287,891,835
Liabilities	815,217,243	707,556,309	1,008,824,717	898,486,664	840,092,993
Capital & Surplus	452,263,593	433,655,157	432,450,713	438,980,361	447,798,842
Premiums Earned	2,352,730,396	2,203,796,039	4,922,898,652	4,188,591,352	3,779,325,821
Net Gain (Loss)	42,175,192	52,271,427	17,601,666	15,868,903	23,761,278

*Per Examination

MARKET CONDUCT ACTIVITIES

Territory

As of December 31, 2002, the Company was licensed to transact business in the State of Alabama. The Certificate of Authority was inspected and found to be in order. The Company is not licensed to conduct health insurance business in any other state. Although the Company's marketing of insurance products is directed only within the State of Alabama, the Company wrote Cost Plus contracts for both regional and national companies, which do business in the State of Alabama. The Alabama companies covered by underwritten plans have covered employees that work and/or live outside Alabama; this is referred to by the Company as a "Host" plan, which is also known as the "Par" Plan.

Plan of Operation

The Company is a non-stock not-for-profit company, which maintains and operates health care plans, under which services are offered to the public. Individuals who participate in a plan are referred to as "subscribers."

The Company marketed both insured health plans and contracts to administer self-insured health plans via salaried sales representatives employed by the Company. The Company's Board of Directors establishes an annual market goal. This goal is then communicated to the various district managers and ultimately to the marketing representatives.

Various policies and plans offered by the Company include the following:

Rural Health Program (an ALFA franchise group);
Individual health care policies; and
Group contracts including underwritten plans and cost plus (self insured) plans.

The Company owned, and in some cases, also managed several other companies, such as:

Alabama Industries Financial Corporation;
The Caring Foundation;
Alabama Child Caring Foundation;
Preferred Care Services, Inc.; and
Cahaba Safeguard Administrators.

The sales representatives employed by BCBSAL, were required to sell life and disability insurance through Greater Alabama Life Agency (GALA) in conjunction with the sale of BCBSAL products.

The Company, doing business as Cahaba Government Benefit Administrators, acted as a fiscal intermediary and carrier under Parts A and B of the U.S. Center for Medicare and Medicaid Services' Medicare Program.

District Offices

BCBSAL maintains a home office and four district offices. Most services and functions are handled at the home office located at 450 Riverchase Parkway East in Birmingham, Alabama. District offices are located in the cities of Birmingham, Huntsville, Montgomery and Mobile.

Advertising

The Company's advertising program revolves mainly around television commercials. Media advertising is primarily through television spots and ads in newspapers throughout Alabama. The Company utilizes various materials produced and provided by the Blue Cross and Blue Shield Association, as well as media spots and materials developed through the Company's advertising agency.

The Company is involved in various civic activities and organizations, and makes contributions to charitable entities, such as, The Caring Foundation, and the Alabama Child Caring Foundation, which also serves to promote name recognition and goodwill.

Claims Processing

Claims are entered into the processing system by electronic transmission, manual keying and scanning. The claims system contains various edits and routines to check the incoming claims. Claims are "flagged" for individual review by a claims examiner when some attribute of the claim calls for additional attention. The Company receives over 70% of physician claims and 90% of hospital claims electronically. Hard copy claims are scanned or imaged and forwarded electronically to the data entry queues where data entry operators verify scanned data or enter data from imaged documents after which the information is released for processing in the claims system.

BCBSAL maintains a Performance Services Department which provides information about claims on a regular basis. The Performance Services Department produces reports which identify information such as claims turnaround and claims inquiry turnaround time. The Company produces a quarterly report that lists the timeliness of clean claims and investigated claims. The following is a synopsis of the Performance Services Department's annual performance results for claims:

Year	Claims Processed	Percent Accurate	Percent Timely
1999	46,084,970	99.57%	97.09%
2000	50,610,430	99.34%	97.40%
2001	56,647,966	99.98%	97.52%
2002	61,281,566	99.69%	96.85%

Medicare Claims Processing

The Company, doing business as Cahaba Government Benefit Administrators, acts as a processing and fiscal intermediary and carrier under Parts A and B of the U.S. Center for Medicare and Medicaid Services' (CMS, formerly Health Care Financing Administration) Medicare program. The Company contracts with CMS to process Medicare Part A in Alabama, Iowa and South Dakota and to process Medicare Part B in Alabama, Georgia and Mississippi. The Company also processes home health claims for fifteen states and the District of Columbia and performs program integrity activities related to the Medicare Part A workload in North Carolina. The Company also acts as a regional processor (i.e. data processing center) for Puerto Rico. Under this program, the Company disburses Federal funds to physicians, hospitals and others on the basis of incurred claims for medical services provided. Neither the remittances received nor the corresponding charges for claims paid are reflected in the Company's financial statements. The claims checks are issued and drawn directly against Federal funds.

Amounts due to the Company for administering this program were based on contractual cost computations and were recorded as receivables. The records of claims and allowable administrative cost reimbursements are audited by governmental auditors or by outside CPA firms. Final settlements for contract periods are negotiated on the basis of the audits.

Policy Forms and Underwriting

Upon the examiners' review of the Company's underwriting practices it was noted that the Company did properly utilize the rates filed and approved by the Alabama Department of Insurance. The Company performed periodic filings with the Alabama Department of Insurance and did not implement the rates calculated until the proper approval was received. The examiner's review focused on whether the rates filed with the Alabama Department of Insurance were properly implemented in underwriting the Company's policies.

The Company writes both individual and group health plans. The individual health plans constituted 8.9 percent of 2002 written premium. The group plans comprised 91.1 percent of the 2002 written premium. Total earned premium for underwritten business in 2002 was $2,319,995,753. Claim reimbursements and administrative fees accrued under Cost Plus uninsured plans were $4,176,393,377.

The following discussions relate to the individual health plans and group health plans that are offered by the Company:

A) Individual Policies

Medicare supplement Plan B under Federal Guidelines

The Medicare supplement policy (C-Plus) has been written to exceed the minimum Federal requirements for a policy to be called a "Medicare supplement policy." The policy has been approved as a Medicare Select Standard Plan B under federal guidelines. There is no health underwriting and no pre-existing condition exclusions applicable to the policy for individuals 65 years of age or older. An individual is automatically accepted during the three months

preceding and the three months following the month that the person turns 65 years of age. The Company has periodic open enrollment periods during which individuals are allowed to apply, even though application is not made at the time age 65 is reached.

Rating is by age at entry and whether the individual is on Medicare Disability. Premium is established on a monthly payment plan. Individuals are required to be enrolled in both Medicare Part A and Part B.

The Medicare supplement application form includes a question as to whether the applicant has in force another Medicare supplement policy and/or is eligible for Medicaid. This is a requirement of Federal government regulations and allows the Company to obtain representation as to whether there is any other Medicare supplement in effect before a BCBSAL Medicare supplement policy is issued. Changes to the policy and rate changes are filed with the Alabama Department of Insurance for approval.

Medicare supplement Plan A under Federal Guidelines

The Company offers a Medicare Supplement called Plan A, which is a federally required Plan if a company offers any Medicare supplemental policies. This plan has a 180-day waiting period for pre-existing conditions that begins on the effective date (at age 65) of coverage. The coverage under Plan B is greater than the coverage under Plan A. This contract offers only one rate, which is payable annually or in monthly installments equaling the annual rate. General discussion under the preceding heading applies to this form as well. Very few of these policies have been issued by the Company.

Conversion Health Care Group Plan Certificate

This policy is available only to subscribers/members who convert from a group plan, regardless of whether the plan was Underwritten or Cost Plus. The individual must apply within 30 days of leaving the plan or within 30 days after the termination of COBRA extension of benefits. This plan is not health underwritten at the time of conversion and has no pre-existing exclusions. There is underwriting for additional family members added later to the policy when not covered at the time of conversion; in which case the policy is issued with pre-existing or waiting periods; however, if the waiting period has been fully satisfied under another Blue Cross and Blue Shield contract, no pre-existing exclusions are applied.

Rates are developed on a community-rated basis for an individual or family, and separate rates are stated for bimonthly and for quarterly payment plans.

Adult Rate Health Care Plan Certificate

This plan is for an adult child no longer eligible to be included on a parent's Blue Cross and Blue Shield contract. The policy is issued with no health underwriting and no pre-existing exclusions for the individual. The individual must apply within thirty days of cancellation from the parent's plan or immediately prior to termination of COBRA extension of benefits. The plan has one rate per individual. However, the rate varies by payment cycle (mode) option.

Non-group Health Care Plan Certificate

This policy is a basic hospital policy, which may be issued on an individual or family basis. These risks are health underwritten with waiting periods and pre-existing exclusions. This plan is community rated with a separate rate for single or family; the rate varies by payment cycle (mode) selected.

B) Group Policies and Contracts

The group underwriting department handles the rate setting or rate determination for both underwritten and Cost Plus business. There are no written guidelines for determining the premium rates for Cost Plus business. The rates are based on the underwriters' overall knowledge and the fundamental experience of the group.

Underwritten (Insured) Group Business

Groups of 2-50 employees are pool-rated. The Company does not look at each individual group's claims experience to determine rates. "Small Group" benefits are re-evaluated each year and rate changes, if any, are usually made once a year. All companies in the state of Alabama who have 2-50 employees are pooled together as one large group.

For insured groups, the employer is required to contribute at least fifty percent of the cost for each individual employee, and there must be at least seventy-five percent participation for family coverage unless their spouse is covered under a group health contract.

Groups of 51+ employees are merit rated groups. Rates for these groups are based partially on the group's actual claims experience adjusted by a trend factor in the market segment for the Company's book of business and partially upon claims experience of the Company's book of business in this market segment. The weight given to the group's experience in this rate calculation increases as the group's size increases. Unlike the fixed coverage available to small groups, merit group account benefits and exclusions are flexible.

Cost Plus Groups

The Company refers to self-insured groups as Cost Plus groups, which are administered by the Company as Administrative Services Contracts (ASC). Contracts are written to provide the coverage desired by the employer, which are within the parameters that the Company is willing to administer. Claims for subscribers/members from these groups are processed along with the underwritten business and paid from Company funds. Although there are a variety of methods to fund a self-insured program, the most common method is a wire transfer arrangement. Under this arrangement the Company notifies the group of the amount of claims paid during the week and the group wires the money to an account specified by the Company. The same subscriber identification cards, service benefit arrangements with network providers, access to conversion privileges upon cessation of eligibility for group coverage, inter-plan transfer program and other benefits of membership are applicable to subscribers/members in both Cost Plus and insured groups.

C) Dental Plan

The Company offers several dental benefit plans. Groups may choose from various levels of options within either traditional or PPO benefits.

Group dental plans are available as part of a health plan or as a dental only plan. These options are available to both underwritten and Cost Plus groups. If both health and dental benefits are purchased, there are two eligibility structures available:

First, dental benefits can be a rider to the health plan. The employee has one contract for both the health plan and the dental rider. One ID card is issued to the subscriber/member. If the group is underwritten and the employee has single coverage, he must also have single dental coverage and vice-versa.

Second, dental benefits can be a freestanding plan and separate from the health plan. This dental plan is offered to groups with 15 or more employees. Employees with this coverage have two separate contracts and two separate identification cards, one for health and one for dental. Enrollment is not open throughout the period of coverage; all enrolled employees must continue this coverage as long as they are eligible and for the period of coverage for the plan. A minimum of 75% of employees with eligible dependents is required to maintain the option for coverage of eligible dependants. The employees must enroll the eligible dependent within thirty days of the effective date of the plan, if coverage is desired after the original and initial date of enrollment. Coverage will not be offered at any other time during the policy period. There is a set monthly rate that applies; one for individual and one for family coverage.

Producer Licensing

The Company's captive marketing representatives have been instructed by the Company to sell life insurance through Greater Alabama Life Agency (GALA), a former subsidiary of the Company, in conjunction with the sale of health insurance. The Company represented that it does not receive any compensation from allowing its representatives to market life insurance. The Company further represented that it was benefited by the coordinated marketing of life and disability products whenever a group customer preferred to arrange their group benefit programs through a single agent.

The Network Marketing Services Agreement between BCBSAL, UTIC and GALA specifies that GALA will coordinate the marketing, agent licensure and servicing of non-BCBSAL products and UTIC products and that "Blue Cross shall provide salary and employee benefit administration services to GALA for all GALA employees."

It appears that "GALA employees" are actually BCBSAL employees: located at an address where BCBSAL has done leasehold improvements, sharing phone extensions, and receiving the same benefits as other BCBSAL employees. The agreement also specifies that "GALA shall reimburse Blue Cross for all direct and indirect costs incurred by Blue Cross." The examiners were not provided any documentation supporting that GALA reimbursed BCBSAL; however, there was documentation provided where funds were received from Fortis Benefits Insurance Company (the parent company of GALA) to BCBSAL,

reimbursing BCBSAL for what appeared to be GALA-related services. See page 42 for related recommendation.

The examiners' contact for this examination represented to examiners that:

"BCBSAL is reimbursed by Fortis for expenses related to life insurance services provided to our customers. **BCBSAL implemented a production award to encourage our marketing associates to offer life insurance coverage to our customers. These awards are not indexed directly to the volume of annualized life premiums sold. BCBSAL is not reimbursed for these production awards."** [emphasis added]

"Award payments encourage BCBSAL marketing associates to offer and support a complete package of insurance to our customers, while at the same time simplifying the administrative support necessary to meet our customers' needs."

The Vice President and Executive Director of GALA indicated to examiners that GALA sells life insurance only to groups that buy health insurance from BCBSAL. Groups may purchase life and disability products on an optional basis. No group is required to buy life and/or disability insurance in order to buy health insurance.

The examiners have reviewed the life insurance marketing practices in light of both the relevant statutes and relevant Alabama case law.

Alabama case law has held:

> ...We can conclude that it was not the intent of the legislature that Blue Cross enter the field of life insurance."
>
> ...10-4-100 sets forth the single purpose for which Blue Cross was organized: that of establishing, maintaining and operating a health care service plan under which health services are furnished to such of the public who become subscribers to such plan. Thus, the one purpose set forth by the legislature for the organization of Blue Cross is the maintenance of a health care service plan for subscribers. Though it is not pertinent to the question before us, it is interesting to note that the evidence shows that, in carrying out its legislative purpose, Blue Cross has apparently become the largest hospital and medical insurer in the state.
>
> There can be no doubt that Blue Cross is a special purpose corporation, organized under 10-4-100 for the specific and limited purpose of maintaining a health care service plan for subscribers...Marketing life insurance is not included in the limited statutory purpose and is thus impermissible.
>
> ...We would simply note again that the powers granted to Blue Cross by 10-4-103 can be no greater than the statutory purpose of maintaining a health care service plan for subscribers. We do not think that the sale of life insurance through a subsidiary can be characterized as incidental to, or even appropriate for, this limited purpose. The fact that marketing both types of insurance may be desirable or profitable to Blue

Cross does not mean that such marketing is necessary and incidental to Blue Cross's limited raison d'etre...

The examiners noted that a sworn affidavit that was signed by the Secretary of the Company before a Notary on February 13, 1989 was filed with the Circuit Court of Montgomery County, Alabama indicated, among other things, that

> "Originally, Blue Cross and Blue Shield of Alabama purchased United Trust Insurance Company for the purpose of engaging in the sale of life insurance. Thereafter, following rulings from this Honorable Court as well as the opinion of the Court of Civil Appeals, this defendant did not and has not sold life insurance, and has no intention of selling life insurance until so authorized by the Alabama legislature."

Through a review of the Company's commission payment practices, it was determined that it did not properly report commissions the 2002 Annual Statement. It was determined that the Company included other payments that did not belong with the commissions that should have been recorded under Salaries, Wages and Other Benefits. See the related recommendation on page 42 under the heading "Important Points, Comments and Recommendations – Producer Licensing."

Treatment of Policyholders and Claimants

The Company's system for recording and keeping complaint data does not provide for the separation of actual complaints from inquiries. It was recommended in the last examination report that a complaints registering system be established and maintained consistent with the recommended guidelines found in the NAIC Market Conduct Examiners Handbook, appendix pages A-12 through A-17. The NAIC requires that the Company keep complete records of its complaints, whether received directly by the Company or through the Department of Insurance. It was determined that the complaints directly received were not properly recorded. See the related recommendation on page 41 under the heading "Compliance with Previous Recommendations – Treatment of Policyholders and Claimants."

There were 253 complaints received by the Alabama Department of Insurance regarding the Company during the examination period. The examiners reviewed the Alabama Department of Insurance complaint records to determine whether the Company was addressing the issues raised by complainants in a timely manner. The examiners also reviewed a sample of policyholder complaints received by the Company. The reviews indicated that the policyholder complaints were responded to in a timely manner and the Company's responses properly addressed the issues raised by the complainants.

Privacy Standards

The Company was not required to comply with the NAIC Privacy Model Regulation, ALA. ADMIN. CODE 482-1-122 (2001), since it was incorporated under ALA CODE § 10-4-103 (1975). It is however required to comply with the Health Insurance Portability and Accountability Act privacy provisions starting April 14, 2003, to which it is in compliance.

The Company did not share customers' personal information with any nonaffiliated third parties. Moreover, any information the Company disclosed to any other third parties was for the purpose of conducting day to day business functions.

Instructions were in place for employees to provide guidelines for the handling of personal information the Company employees or affiliated parties might have had access to.

The Company provided notices to its customers that indicated the types of information it collected, the way it is used and the manner of collection. The notices also informed the customers that the Company did not disclose any information to any nonaffiliated third parties unless permitted to do so by law.

The Company's disclosure of any health information was made only after authorization from its customers unless the disclosures were made under section 17B of the NAIC Privacy Model Regulation.

REINSURANCE

The Company had a reinsurance contract to cede a portion of its new Long-Term Care product to Munich American Reassurance Company (MARC). This was the only type of insurance that was reinsured as of December 31, 2002. The Company was marketing, writing and selling the long-term care policies. However, the Company had chosen to outsource the underwriting function of the Long-Term Care product to Life Plans, Inc. Life Plans, Inc. made the underwriting decisions based on underwriting guidelines agreed to by Senior Management of the Company, Life Plans, Inc. and MARC. The policy stated that if Life Plans, Inc. approved a contract to MARC, the Company would deduct a ceding allowance from the amount remitted to MARC based on the percentage of the premium, which was approximately 6%. This was done on a monthly basis.

For all claims on policies that are paid less than or equal to the equivalent value of 1,825 days of claims payments (Pre-Five Year Claims), MARC reinsures 50% of the risk up to the Company's Maximum Daily Benefit Amount of $300. For claims on policies that are paid the equivalent value of more than 1,825 days of claims payments (Post-Five Year Claims), MARC will reinsure 80% of the risk up to the Company's Maximum Daily Benefit. At any time after the Company has placed 1,500 policies in force, the Company has the option of retaining up to 80% of the risk up to the Maximum Daily Benefit Amount on new business, upon providing written notice to MARC. As of December 31, 2002, no claims had been filed.

The Company did not properly complete Schedule S - Part 2 in the 2002 Annual Statement. The Company was listed as the reinsuring company when it should have been Munich American Reassurance Company.

It was noted that the Company did not have established standards of acceptability for reinsurers or a formal internal quality control program to regularly monitor the accuracy of transactions processed. However, the Manager of Financial Reporting and Analysis stated that a report showing reinsurance premium amounts and ceding allowance amounts by

individual contract is produced each month. Associates in Customer Accounts and Financial Reporting and Analysis review this report prior to amounts being wired to Munich American Reassurance.

The recommendations relating to reinsurance are located on page 42 under "Important Points, Comments and Recommendations – Reinsurance."

ACCOUNTS AND RECORDS

In 1998, the Company entered into a court approved settlement relating to a class action lawsuit which challenged the size, level and composition of the unassigned funds of the Company. The authorized level of unassigned funds agreed to by the Company was approved by the Alabama Department of Insurance on August 25, 1998. In accordance with the settlement, the Company is required to maintain its unassigned funds within an approved range. The approved range is between 110% and 250% of the computed capital benchmark measure. The manner in which the capital benchmark measure is to be computed is stipulated in the settlement agreement.

The Company incorrectly calculated the capital benchmark for year end 2001 and year end 2002. A corrected calculation for 2001 and 2002 was filed with the Alabama Department of Insurance on October 27, 2003. The examiners recomputed the capital benchmark and the approved minimum and maximum levels of unassigned funds. The examiners noted an additional error in the capital benchmark calculation as of year-end 2002 related to the amount of rate stabilization reserves reported as a component of the calculation. After correcting the 2002 capital benchmark, the Company's unassigned funds remained within the approved range for unassigned funds.

The Company incorrectly reported the amount of current year accrued interest used to calculate line 1.2 of column 2 of the Exhibit of Net Investment Income in the 2002 Annual Statement. Temporary write downs of two securities due to their NAIC ratings being lowered to 3 were included in the interest collected during year calculation. The Company did not include the bond adjustments in the net investment income calculation since it was already included in the Exhibit of Capital Gains (Loss), so it was determined to offset the adjustment with the amount of income due and accrued used to calculate the Interest Earned During the Year.

The Company allowed the Executive Vice President, Vice President/Controller and Manager of Cash Management and Investments to establish and/or maintain accounts with banks to purchase, invest in, or otherwise dispose of and generally to deal in all forms of securities authorized by the Board of Directors. The only person authorized by the Board of Directors to have this right is the Senior Vice President of Finance and Treasurer.

An excessive number of individuals had access to the Company's computer rooms, both on-site and off-site. There were 240 ID cards that could gain access to the on-site computer room and 124 ID cards that could gain access to the off-site tape storage room. Some employees, including Company executives, had up to six ID cards. During the examination

the Company took action and reduced the number of ID cards with access to the on-site computer room by seventy-seven.

There were employees that had access to computer information that did not pertain to their job description. The Company should limit its employee's access to only the information that is needed to perform their job duties.

The related recommendations are located on page 42 under "Important Points, Comments and Recommendations – Accounts and Records."

FINANCIAL STATEMENTS

The Financial Statements included in this report were prepared on the basis of the Company's records, and the valuations and determinations made during the examination for the year 2002. Amounts shown in the comparative statements for the years 1999, 2000 and 2001 were compiled from Company copies of filed Annual Statements. The statements are presented in the following order:

Blue Cross and Blue Shield of Alabama
Statement of Assets, Liabilities, Surplus and Other Funds*
For the Year Ended December 31, 2002

Assets

	Ledger Assets	Non-ledger Assets	Assets Not Admitted	Admitted Assets
Bonds (Note 1)	$ 600,133,997	$	$	$ 600,133,997
Common Stocks (Note 2)	89,008,215		12,387,047	76,621,168
Real estate - Properties occupied by the company (Note 3)	115,515,547			115,515,547
Cash (Note 4)	1,566,591			1,566,591
Short-term investments (Note 4)	116,224,739			116,224,739
Accident and health premiums due and unpaid	175,425,335	1,117,463		174,307,872
Health care receivables (Note 5)	65,801,662	26,557,421	11,339,499	27,904,742
Investment income due and accrued	8,992,240			8,992,240
Amounts due from parent, subsidiaries and affiliates	199,589			199,589
Amounts receivable relating to uninsured accident and health plans (Note 6)	98,411,987	3,120,099		95,291,888
Furniture and equipment	34,345,588	34,345,588		
Federal and foreign income tax recoverable and interest thereon	234,699,786	226,247,187		8,452,599
Electronic data processing equipment and software (Note 7)	79,567,587	68,118,514		11,449,073
Other nonadmitted assets	20,749,117	20,749,117		
Aggregate write-ins for other then invested assets	7,094,245			7,094,245
Total Assets	$ 1,647,736,225	$ 380,255,389	$ 23,726,546	$ 1,243,754,290

Liabilities, Surplus and Other Funds

Liabilities:	
Claims unpaid (Note 8)	$ 252,898,036
Unpaid claims adjustment expenses	6,498,671
Aggregate policy reserves	277,100,216
Premiums received in advance	32,716,999
General expenses due or accrued (Note 9)	148,346,655
Federal and foreign income tax payable and interest thereon	16,092,137
Amounts withheld or retained for the account of others (Note 10)	36,256,902
Amounts due to parent, subsidiaries and affiliates	185,000
Liability for amounts held under uninsured accident and health plans (Note 11)	45,122,627
Total Liabilities	$ 815,217,243
Capital and Surplus:	
Unassigned funds (Note 12)	428,537,047
Total Liabilities, Capital and Surplus	$ 1,243,754,290

* The discussions in the forepart of this report, as well as, notes and discussions following the financial statements are an integral part thereof.

Blue Cross and Blue Shield of Alabama
Statement of Revenue and Expenses*
For the Years Ended December 31, 2002, 2001, 2000, and 1999

	2002	2001	2000	1999
Net premium income	$ 2,352,730,396	$ 2,203,796,039	$	$
Change in unearned premium reserves and reserve for rate credit	(32,734,643)	(31,616,650)		
Aggregate write-ins for other health care related revenues			4,922,898,652	4,188,591,352
Total revenue	$ 2,319,995,753	$ 2,172,179,389	$ 4,922,898,652	$ 4,188,591,352
Medical and Hospital:				
Hospital/medical benefits	$ 1,389,530,384	$ 1,290,981,039	$	$
Other professional services	414,320,533	544,973,897		
Emergency room and out-of-area	109,927,329	96,098,899		
Prescription Drugs	207,412,093			
Aggregate write-ins for other medical and hospital			4,831,020,685	4,122,467,827
Subtotal	$ 2,121,190,339	$ 1,932,053,835	$ 4,831,020,685	$ 4,122,467,827
Less:				
Total medical and hospital	$ 2,121,190,339	$ 1,932,053,835	$ 4,831,020,685	$ 4,122,467,827
Claims adjustment expenses	42,013,643	65,880,063	113,571,655	106,953,044
General administrative expenses	125,827,497	132,250,123		
Increase in reserves for accident and health contracts				
Total underwriting deductions	$ 2,289,031,479	$ 2,130,184,021	$ 4,944,592,340	$ 4,229,420,871
Net underwriting deductions	$ 30,964,274	$ 41,995,368	$ (21,693,688)	$ (40,996,780)
Net investment income earned	$ 36,213,935	$ 37,403,694	$ 40,308,197	$ 41,710,228
Net realized capital gains or (losses)	(7,003,017)	(3,022,816)	1,132,157	16,218,602
Net Investment gains or (losses)	$ 29,210,918	$ 34,380,878	$ 41,440,354	$ 57,928,830
Net income or (loss) before federal income taxes	$ 60,175,192	$ 76,376,246	$ 19,746,666	$ 17,266,592
Federal and foreign income taxes incurred	18,000,000	24,104,819	2,145,000	1,397,689
Net income (loss)	$ 42,175,192	$ 52,271,427	$ 17,601,666	$ 15,868,903

The discussions in the forepart of this report, as well as, notes and discussions following the financial statements are an integral part thereof.

Blue Cross and Blue Shield of Alabama
Capital and Surplus Account*
For the Years Ended December 31, 2002, 2001, 2000 and 1999

	2002	2001	2000	1999
Capital and surplus prior reporting year	$ 433,655,157	$ 432,450,713	$ 438,980,361	$ 447,798,842
Gains and Losses to Capital & Surplus:				
Net income or (loss)	42,175,192	52,271,427	17,601,666	15,868,903
Net unrealized capital gains and losses	(22,420,335)	(1,796,345)	(3,215,262)	(6,627,755)
Change in net deferred income tax	18,419,878	29,772,842		
Change in nonadmitted assets	(43,292,845)	(33,905,280)	(24,095,882)	(17,074,629)
Cumulative effect of changes in accounting principles		(45,138,200)		
Aggregate write-ins for gains or (losses in surplus			3,179,830	(985,000)
Net change in capital & surplus	$ (5,118,110)	$ 1,204,444	$ (6,529,648)	$ (8,818,481)
Capital and surplus end of reporting year	$ 428,537,047	$ 433,655,157	$ 432,450,713	$ 438,980,361

* The discussions in the forepart of this report, as well as, notes and discussions following the financial statements are an integral part thereof.

NOTES TO FINANCIAL STATEMENTS

Note 1 – Bonds **$600,133,997**

The above captioned amount is the same as reported in the 2002 Annual Statement.

At December 31, 2002, none of the Company's custody agreements were approved by the Commissioner of the Alabama Department of Insurance as required by ALA. ADMIN. CODE 482-1-077-.04 2(o) (2003), which states, "The custody agreement is of no force and effect until the Commissioner approves, in writing, the custody agreement." All assets in the accounts with custodial agreements that have not been approved by the Commissioner of Insurance should be not admitted and as required by ALA. ADMIN. CODE 482-1-077-.04 3 (2003), which states, "Any securities that are not held in compliance with this chapter shall be not admissible assets for financial reporting purposes." Due to the Company's custodial agreements being approved by the Commissioner of Insurance subsequent to the exam period an adjustment to surplus was not made to this item.

The Company only updates cash flow projections for their mortgage-backed securities once or twice a year unless they encounter a reason to update more frequently, which is not in compliance with SSAP No. 43 paragraph 10, which states:

> Changes in prepayments assumptions and the resulting cash flows shall be reviewed periodically. For securities that have the potential for loss of a portion of the original investment due to changes in interest rates or prepayments, the review shall be performed at least quarterly....

The Company's Israel Government Trust bond with a CUSIP number of 383752DW9 and Greece Government Trust bond with a CUSIP number of 38375HBJ7 were listed with a NAIC designation of "1" but according to the NAIC SVO these securities are designated as "1PE."

The Company neglected to include the SVO certification in the 1st quarter 1999, 3rd quarter 2000, and 2nd quarter 2002 statements as required on page 29 of the NAIC Annual Statement Instructions Health which states, "There is to be completed and attached to each quarterly and annual statement of the Company a certification that all requirements of the NAIC Securities Valuation Office (SVO) have been met in a timely fashion."

Related recommendations can be found on page 43 under the heading "Important Points, Comments and Recommendations – Note 1 – Bonds."

Note 2 – Common Stock **$76,621,168**

The above captioned amount is $12,387,047 less than the $89,008,215 reported in the 2002 Annual Statement.

After checking with the NAIC's Securities Valuation Office, it was determined that the only documentation found for any of the Company's SCA investments was a SUB 1-form for

Alabama Industries Financial Corp. It is required that a SUB 1-form be completed and submitted within 30 days of the acquisition or formation of a new SCA investment in accordance with the Purposes and Procedures of the NAIC Securities Valuation Office Part 8, Section 2 (a), which states:

> Not later than June 1 for existing SCA investments, and within 30 days of the acquisition or formation of a new SCA investment, an insurance company shall calculate the value of its common stock investments in insurance and non-insurance company SCA companies and report the value to the SVO.

After checking with the NAIC's Securities Valuation Office, it was also determined that the Company has filed no SUB 2-forms for any of its SCA investments. The Purposes and Procedures of the NAIC Securities Valuation Office Part 8, Section 2 (c) iii states, "By June of each year, any insurance company that has made a SUB 2-form filing in a previous year must update the information by filing an updated SUB 2-form filing."

Due to the Company not filing the proper forms with the NAIC Securities Valuation Office, the value of Alabama Industries Financial Corp, Preferred Care Services, and Investment in Membership of CSA, LLC were nonadmitted.

The Company failed to submit the information necessary to enable the SVO to complete its annual review of BCSI Holdings, Inc. This is not in compliance with the Purposes and Procedures Manual of the NAIC Securities Valuation Office, Part 5, page 12, section 4 (a) (ii) which states:

> Any insurance company that owns a security listed in the VOS publication, which is not provisionally exempt as set forth in Part Four, Section 1(a)(ii), can satisfy subsequent reporting requirements by filing the additional or annual information described below. For purposes of this Manual, it is assumed that reporting responsibility is borne by the company that has filed the Initial Report. However, the SVO recognizes the possibility that the initial reporting insurance company may have sold its investment. Therefore, any insurance companies with an interest in a security may need to submit the information necessary to enable the SVO to complete its annual review. Annual filings should be reported to the SVO on the Annual ATF.

The Company's carrying value of its investment in BCSI Holdings, Inc. was not material as of December 31, 2002 and no adjustment to surplus was made for this item.

Related recommendations can be found on page 43 under the heading "Important Points, Comments and Recommendations – Note 2 – Common stocks."

Note 3 - Real Estate **$115,515,547**

The above captioned amount is the same as reported in the 2002 Annual Statement.

In the previous exam, it was recommended that the Company only include real estate purchased during the year and capital improvements on those properties in accordance with

the NAIC Annual Statement Instructions for Health. It was also noted that the same recommendation was made in the exam preceding that exam. Amounts expended during the year for additions and permanent improvements on real estate owned at prior year-end and held at current year-end should be entered on Schedule A, Part 1 and not reported on Schedule A, Part 2.

At December 31, 2002, the Company reported $14,268,000 for 2002 property rental expense on Note 15A (1) of the 2002 Notes to Financial Statements. However, this amount should have been $19,374,000.

Related recommendations can be found on page 41 under the heading "Compliance with Previous Recommendation – Note 3 – Real estate" and on page 43 under the heading "Important Points, Comments and Recommendations – Note 3 – Real estate."

Note 4 - Cash and short-term investments **$117,791,330**

The above captioned amount is the same as reported in the 2002 Annual Statement.

The Company neglected to include on the Exhibit of Net Investment Income, interest that they had received from the interest bearing Mellon Bank Account under the amount collected during the year. This interest, which totaled $194,398, was included in Schedule E; page E24.1, Col 3 of the 2002 Annual Statement.

A related recommendation can be found on page 44 under the heading "Important Points, Comments and Recommendations – Note 4 – Cash and short-term investments."

Note 5 – Health Care Receivables **$27,904,742**

The above captioned amount is $11,339,499 less than the $39,244,241 reported in the 2002 Annual Statement.

At December 31, 2002, the Company utilized SSAP No. 25 to determine admissibility, collectibility and the correct reconciliation method of its loans or advances to providers. However, it was determined that the loans or advances to providers were not related party transactions. The Company should determine the correct admissibility, collectibility and reconciliation method of its loans or advances to providers in accordance with SSAP No. 84.

At December 31, 2002, the Company admitted $11,232,481 of provider advance accounts which did not meet the requirements for admissibility as stipulated by SSAP No. 84, paragraph 16 which states that:

> In addition, a loan or advance to a non-related party hospital shall be admitted up to the amount of claims incurred and payable to the hospital if all of the following conditions are met:
> a. The loan or advance meets the setoff conditions in SSAP No. 64;
> b. The loan or advance is supported by a legally enforceable contract;
> c. The loan or advance is administered pursuant to contractual terms;

d. The contractual terms of the agreement provide for separate quarterly reconciliations;
e. Each quarterly reconciliation shall be completed within nine months of the end of such quarter; and
f. A quarterly reconciled difference shall be settled within 90 days of the date the reconciliation is completed.

It was determined that the Company had not recognized offsetting liabilities in relation to certain provider advances and the conditions of setoff, as stipulated by SSAP No. 64, did not exist, and therefore were nonadmitted.

The Company reported its claim overpayment receivables as nonadmitted at December 31, 2002. These receivables were nonadmitted because there were no determinable amounts to provide a right of offset, in accordance with SSAP No. 84, paragraph 14. However, there were three claim overpayment receivable accounts which were inadvertently admitted. Since these accounts, which totaled $107,018, did not meet the setoff conditions of SSAP No. 84, paragraph 14, they were nonadmitted.

The Company's personnel explained that, if after 75 days the Company's claim overpayments invoices had not been paid, the overpayment amount are released to the ACRE system where monies are withheld from future remittances until the balance is satisfied. When a provider/subscriber number is cancelled and no longer doing business with the Company, no more claims will be submitted for payment under that number. The balance will remain on ACRE for three years after the number has been cancelled. At that point, it is highly unlikely that any monies will be received for the existing balances. These balances are written off at this time as they are considered uncollectible. This is when the overpayment is charged to bad debt expense. However, SSAP No. 84, paragraph 14 provides that if it is probable that a receivable balance is uncollectible, the uncollected balance should be written off and charged to income. It was determined that the Company is not in compliance with SSAP No. 84, paragraph 14. The fact that the Company does not consider balances to be uncollectible and written off until three years is unreasonable. An evaluation of the collectibility should be made when the claim overpayments are ninety days past due.

At December 31, 2002, the Company incorrectly aged its pharmaceutical rebate receivables on Exhibit 4 - Health Care Receivables. However, the incorrect aging did not affect the admitted amounts for this receivable. The Company should age its pharmaceutical rebate receivables in accordance with the NAIC Annual Statement Instructions.

The Company did not disclose the method used to estimate pharmaceutical rebate receivables in the Notes to Financial Statements of the 2002 Annual Statement. SSAP No. 84, paragraph 24 states to disclose the method in the financial statements. Furthermore, the NAIC Annual Statement Instructions states to disclose such method in the Notes to Financial Statements, No. 20, H, (1).

Related recommendations can be found on page 44 under the heading "Important Points, Comments and Recommendations – Note 5 – Health care receivables."

Note 6 – Amounts receivable relating to uninsured accident and health plans **$95,291,888**

The above captioned amount is the same as that reported in the 2002 Annual Statement.

The general ledger account in which the national self insured receivables over ninety days due are recorded was reported as an admitted asset. Uncollected uninsured plan receivables over ninety days past due are to be nonadmitted in accordance with SSAP No. 47, paragraph 9 which states "Uncollected uninsured plan receivables (excluding Medicare and similar government plans) over ninety days due shall be accounted for as a nonadmitted asset." The amount that should have been nonadmitted was $36,286 which is immaterial. The related recommendation can be found on page 44 under the heading "Important Points, Comments and Recommendations – Note 6 – Accounts receivable relating to uninsured accident and health plans."

Note 7 – Electronic data processing equipment and software **$11,449,073**

The Notes to Statutory-Basis Financial Statements of the 2002 Audited Annual Report states that the Company depreciated electronic data processing (EDP) equipment using straight-line depreciation over a three year period. However, it was noted that the Company was depreciating EDP assets purchased in 1999 and 2000 over a five year period instead of the lesser of their remaining life or three years as required by SSAP No. 79, paragraph 5. The Company's Tax Accounting Manager stated that the implementation of SSAP No. 79 would have been very costly and resulted in additional depreciation expense of approximately $500,000 or an increase in administrative expenses of approximately 0.36%, which is immaterial to the Company. Management evaluated the implementation of SSAP No. 79 and determined that the cost of the implementation exceeded the benefits. Therefore, the Company chose to follow paragraph 49 of the Preamble to the NAIC Accounting Practices and Procedures Manual which states, "The provisions of this Manual need not be applied to immaterial items." This information should be included in the Notes to Statutory-Basis Financial Statements in the 2002 Audited Annual Report in accordance with SSAP No. 16, paragraph 5.

Note 8 – Claims unpaid **$252,898,036**

The above captioned amount is the same as reported in the 2002 Annual Statement.

The Company did not separate and report its claims payable as reported and unreported at December 31, 2002. The NAIC Annual Statement Instructions require claims payable to be reported separately as "reported" and "unreported" when completing Exhibit 5 - Claims Payable (Reported and Unreported). The Company did not properly complete Exhibit 5, Aging Analysis of Unpaid Claims.

Related recommendations can be found on page 44 under the heading "Important Points, Comments and Recommendations – Note 8 – Claims unpaid."

Note 9 – General expenses due or accrued **$148,346,655**

The above captioned amount is the same as reported in the 2002 Annual Statement.

At December 31, 2002, the Company reported $46,308,623 for the 2002 defined benefit pension plan accrued liability in Note 12A of the 2002 Notes to Financial Statements. However, the correct amount at year end was $46,011,385. The correct amount was included on the balance sheet under General expenses due and accrued; therefore, no changes were made to the financial statements.

At December 31, 2002, the Company reported $530,276 for the 2002 postretirement plans accrued liability in Note 12A of the 2002 Notes to Financial Statements. However, the correct amount at year end was $43,653,389. The correct amount was included on the balance sheet under General expenses due and accrued; therefore, no changes were made to the Financial Statements.

Related recommendations can be found on page 45 under the heading "Important Points, Comments and Recommendations – Note 9 – General expenses due or accrued."

Note 10 – Amounts withheld or retained for the account of others **$36,256,902**

The captioned amount is the same as reported in the Company's 2002 Annual Statement.

During the review of the Amounts withheld for the account of others it was determined that unclaimed checks bearing 1996 and 1997 dates were not escheated to the State Treasurer Unclaimed Property Division. The Company's position was explained by Company personnel from the Company's Legal Division. The position provided was as follows. The issue of whether ERISA preempts state unclaimed property is not settled under the case law of the 11th Circuit Court. Historically, the Company had remitted all unclaimed amounts relating to the health plans administered. However, two years ago (for checks dated 1996 and 1997), the Company sought outside legal advice on the subject and was advised that it was reasonable to take the position that such laws are preempted by ERISA. When the Company reconsidered the issue during 2003, it was decided to revert to the previous policy of remitting unclaimed property unless a self-funded group instructed the Company to do otherwise for payments made on their behalf. This is the Company's current policy.
A related recommendation can be found on page 45 under the heading "Important Points, Comments and Recommendations – Amounts withheld or retained for the account of others."

Note 11 – Liability for amounts held under uninsured accident and health plans **$45,122,627**

The above captioned amount is the same as reported in the 2002 Annual Statement.

The Company inaccurately included, within the "Amounts withheld or retained for the account of others" line item, advanced deposits that were to be refunded to various uninsured accident and health plans upon changes in financial arrangements or termination

of contracts. NAIC Annual Statement Instructions state to exclude any liability relating to uninsured accident and health plans from the "Amounts withheld or retained for the account of others" line item and include these amounts within the "Liability for amounts held under uninsured accident and health plans" line item. The amount misclassified was $2,158,600.

A related recommendation can be found on page 45 under "Important Points, Comments and Recommendations – Note 11 – Liabilities for amounts held under uninsured accident and health plans."

Note 12 – Unassigned Funds **$428,537,047**

The above captioned amount is $23,726,546 less than the $452,263,593 reported in the 2002 Annual Statement.

The following is a summary of the adjustments made within the report:

Assets: Increase/(Decrease)	
Common stocks	$ (12,387,047)
Health care receivables	$ (11,339,499)
Total adjusted items	$ (23,726,546)

CONTINGENT LIABILITIES AND PENDING LITIGATION

The review of contingent liabilities and pending litigation included the following:

- an inspection of representations made by management to the Company's independent certified public accountants regarding the Company and its subsidiaries;
- a review of the report on litigation and claims made by the Company counsel to the Company's independent certified public accountants;
- a review of a report to the examiners on pending litigation made by Company counsel; and
- a general review of the Company records and files conducted during the course of the examination including a review of claims.

The Company disclosed that assets and liabilities in relation to a certain deferred compensation plan were not reported in the Financial Statements as of December 31, 2002. It was subsequently determined that this plan, referred to as the "rabbi trust," is irrevocable and is not protected from the claims of creditors in the event of insolvency. Therefore, it was determined that the assets and liabilities in relation to this plan should be placed on the balance sheet. During the second quarter of 2003 a prior period adjustment of $6,527,048 was recorded to recognize the statutory value of the assets in the rabbi trust as of December 31, 2002 that exceeded the liabilities that had not previously been reported for the plan.

SUBSEQUENT EVENTS

No significant subsequent events were noted.

COMPLIANCE WITH PREVIOUS RECOMMENDATIONS

A review was conducted during the current examination with regard to the Company's compliance with the recommendations made in the previous examination report. This review indicated that the Company has satisfactorily complied with those recommendations, with the exception of certain items, which are commented on and reaffirmed below:

Corporate Records – Page 10

It is again recommended that all investment transactions be approved by either the Company's Board of Directors or a subordinate committee thereof and reflect this approval in the minutes of the meetings.

It is again recommended that the Annual Statement Interrogatories be correctly answered.

Management and Service Agreements – Page 13

It is again recommended that the Company file all management and service agreements and amendments with the Alabama Commissioner of Insurance for approval in compliance with ALA. CODE § 27-29-4 (1975).

Treatment of Policyholders and Complainants – Page 27

It is again recommended that the Company continue its efforts to include all subscribers, groups, and provider's correspondence in the automated system. The Company should also utilize the codes developed to properly separate actual complaints from inquiries or questions sent in by any subscribers, groups or providers consistent with NAIC recommended guidelines found in the Market Conduct Examiners Handbook.

Note 3 - Real Estate – Page 35

It is again recommended that Schedule A, Part 2 be completed in accordance with the NAIC Annual Statement Instructions. Amounts expended during the year for additions and permanent improvements on real estate owned at prior year-end and held at current year-end should be entered on Schedule A, Part 1 and not reported on Schedule A, Part 2.

IMPORTANT POINTS, COMMENTS AND RECOMMENDATIONS

The following summary presents the important points, comments and recommendations which are made in the current report of examination.

Income Tax Allocation Agreements – Page 16

It is recommended that the Company have in place written tax sharing agreements approved by the Board of Directors as required by SSAP No. 10, paragraph 23 b.

It is recommended that the Company's tax sharing agreements state a specific settlement period within 90 days of filing the consolidated income tax return in accordance with SSAP No. 10, paragraph 13.

Employee and Agent Welfare – Page 18

It is recommended that the Company update its annual Conflict of Interest statement to ask if employees have ever been convicted of a felony to ensure compliance with the Violent Crime Control and Law Enforcement Act of 1994, US Code, Title 18, Section 1033 (e) (1) (A), which in part, prohibits individuals who have been convicted of specified criminal activity from engaging in the business of insurance without written consent from the [sic Alabama] Commissioner of Insurance.

Producer Licensing – Page 25

It recommended that the Company comply with the agreement it has with Greater Alabama Life Agency (GALA) or amend the agreement to reflect its current practices.

It is recommended that the Company not classify salaries and bonuses as commissions.

Reinsurance – Page 28

It is recommended that the Company properly complete Schedule S - Part 2 by listing the reinsuring company and all information pertaining to that company in accordance with the NAIC Annual Statement Instructions.

It is recommended that the Company establish standards of acceptability for reinsurers and a formal internal quality control program to regularly monitor the accuracy of transactions processed.

Accounts and Records – Page 29

It is recommended that the Company correctly calculate the capital benchmark in accordance with its settlement agreement.

It is recommended that the Company include Due and Accrued interest in the Exhibit of Net Investment Income, which reconciles to the other supporting schedules/exhibits of the Annual Statement.

It is recommended that the Board of Directors properly authorize the individuals that establish and/or maintain accounts with banks to purchase, invest in, or otherwise dispose of and generally to deal in all forms of securities authorized by the Board of Directors.

It is recommended that access to both the on-site and off-site computer rooms be limited to only necessary employees.

It is recommended that there only be one active ID card for each employee.

It is recommended that the Company limit its employee computer access to only information pertaining to that employee's job description to ensure a higher level of security.

Note 1 – Bonds – Page 34

It is recommended that the Company obtain approval of all custody agreements from the Commissioner of Insurance as required by ALA. ADMIN. CODE 482-1-077.04 2(o) (2003).

It is recommended that the Company update cash flow projections for their mortgage-backed securities at least quarterly, as required by SSAP No. 43 paragraph 10.

It is recommended that the Company report the correct designation for securities reported in their Annual Statement.

It is recommended that the Company complete and include a certification that all requirements of the NAIC Securities Valuation Office (SVO) have been met in a timely fashion as required by page 29 of the NAIC Annual Statement Instructions.

Note 2 – Common Stock – Page 34

It is recommended that the Company file a SUB 1-form with the NAIC SVO within 30 days of acquisition or formation of a new SCA investment, as required by the Purposes and Procedures Manual of the NAIC Securities Valuation Office of the NAIC Part 8, Section 2 (a).

It is recommended that the Company file a SUB 2-form with the NAIC SVO by June of each year after the filing of the SUB 1-form for the SCA, as required by the Purposes and Procedures Manual of the NAIC Securities Valuation Office of the NAIC Part 8, Section 2 (c).

It is recommended that the Company file all necessary forms with the SVO in a timely manner as required by the Purposes and Procedures Manual of the NAIC Securities Valuation Office Part Five, page 12, section 4 (a) (ii).

Note 3 - Real Estate – Page 35

It is recommended that the Company report the correct amount for lessee operating leases on Note 15A (1) of the Notes to Financial Statements.

Note 4 – Cash and short-term investments – Page 36

It is recommended that the Company report all interest received from investments in their Exhibit of Net Investment Income in the Annual Statement.

Note 5 – Health care receivables – Page 36

It is recommended that the Company utilize SSAP No. 84 to determine admissibility of its loans or advances to providers.

It is recommended that the Company non-admit advances to providers which do not meet the conditions of SSAP No. 84, paragraph 16.

It is recommended that the Company non-admit claim overpayment receivables which do not meet the setoff conditions in accordance with SSAP No. 84, paragraph 14.

It is recommended that the Company comply with SSAP No. 84, paragraph 14 which states, "Evaluation of the collectibility of claim overpayment receivables shall be made periodically. If in accordance with SSAP No. 5, it is probable the balance is uncollectible, any uncollectible receivable shall be written off and charged to income in the period the determination is made."

It is recommended that the Company age pharmaceutical rebate receivables in accordance with NAIC Annual Statement Instructions.

It is recommended that the Company comply with the NAIC Annual Statement Instructions and SSAP No. 84, paragraph 24 which state to "disclose the method used by the reporting entity to estimate pharmaceutical rebate receivables" when completing the Notes to Financial Statements, No. 20, H, (1).

Note 6 - Accounts receivable relating to uninsured accident and health plans – Page 38

It is recommended that the Company report its Accounts receivable relating to uninsured accident and health plans in accordance with SSAP No. 47, paragraph 9.

Note 7 – Electronic data processing equipment and software – Page 38

It is recommended that the Company disclose the method of depreciation and the number of years that electronic data processing equipment is depreciated in the Notes to the Financial Statements of the Audited Annual Report in accordance with SSAP No. 16, paragraph 5 and the NAIC Annual Statement Instructions.

Note 8 – Claims unpaid – Page 38

It is recommended that the Company complete Exhibit 5 - Claims Payable (Reported and Unreported) in accordance with the NAIC Annual Statement Instructions.

It is recommended that the Company comply with the NAIC Annual Statement Instructions for completing Exhibit 5, Aging Analysis of Unpaid Claims.

Note 9 – General expenses due or accrued – Page 39

It is recommended that the Company report the correct amount for defined benefit pension plans accrued liability in Note 12A of the 2002 Notes to Financial Statements.

It is recommended that the Company report the correct amount for postretirement plans accrued liability in Note 12A of the 2002 Notes to Financial Statements.

Note 10 – Amounts withheld or retained for the account of others – Page 39

It is recommended that the Company disclose to the State Treasurer Unclaimed Property Division their past and present practices relating to the escheatment of unclaimed property.

Note 11 – Liability for amounts held under uninsured accident and health plans – Page 40

It is recommended that the Company exclude from Amounts withheld or retained for the accounts of others any liabilities relating to Liability for amounts held under uninsured accident and health plans and report the amount properly in accordance with the NAIC Annual Statement Instructions.

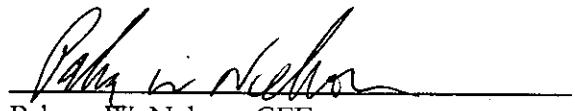
CONCLUSION

Acknowledgement is hereby made of the courteous cooperation extended by the officers and employees of Blue Cross and Blue Shield of Alabama during the course of this examination.

The customary insurance examination procedures, as recommended by the National Association of Insurance Commissioners, have been followed to the extent deemed appropriate in connection with the verification and valuation of assets and determination of liabilities set forth in this report.

In addition to the undersigned, Mary B. Packard, CPA, CFE; Douglas Brown; Tisha Freeman; Douglas Moseley; Jayne Pearce; Shaun Sori and Lori Wright, examiners for the State of Alabama Department of Insurance; and Harland A. Dyer, ASA, MAAA, Consulting Actuary, participated in this examination of Blue Cross and Blue Shield of Alabama.

Respectfully submitted,



Palmer W. Nelson, CFE
Examiner-in-charge
State of Alabama
Department of Insurance